



WELCOME TO OUR PRACTICE- TELL US ABOUT YOURSELF

Name: _____ Today's Date: _____
Date of Birth _____ SS#: _____ Male ☐ Female ☐
Address: _____ City _____ State _____ Zip _____
Cell#: _____ Home#: _____ Work#: _____ Preferred #: C ☐ W ☐ H ☐
Email Address: _____
Is it ok for us to email or text you about your appointments? ☐ YES ☐ NO
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner
Patient or Parent's Employer: _____ Occupation: _____
Spouse or Parent/Guardian's Name: _____ Employer: _____
How Did You Hear About Our Office? _____
How Can We Help You Today? _____

Here, Dr. Brieese can take care of your basic dental needs but we can also provide more premium and elective services. Please check any services below that interest you:

- | | | |
|--|---|--|
| ☐ Dental Implants | ☐ Teeth Whitening | ☐ Invisalign or Braces |
| ☐ Sedation Dentistry | ☐ Porcelain Veneers | ☐ Smile Makeover |
| ☐ Wisdom Teeth Removal | ☐ Smile Transformations | ☐ Partial/Complete Dentures |
| ☐ Sleep Apnea Treatment | ☐ Night/Sports Guards | ☐ Gum Treatment/Cleanings |
| ☐ Bonding | ☐ Tooth Grinding Treatment | |

Insurance Information - Primary

I DO NOT HAVE DENTAL INSURANCE ☐

Subscriber Name: _____ Relationship to Patient: _____
Subscriber DOB: _____ Subscriber SSN#/ID: _____
Insurance Company Name: _____ Subscriber Employer: _____
Insurance Phone #: _____ Group#: _____ Policy/ID#: _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have read and understood the information above and have provided accurate information to the questions provided. I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me or my child to 3rd party payors and/or health care professionals. I also understand that I am financially responsible for all charges whether or not paid by insurance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian: _____ Today's Date: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ YES ☐ NO Physician's Name: _____

Do you also see a medical specialist? (i.e cardiologist, etc) ☐ YES ☐ NO

List type of Specialist and their name/location: _____

List the current medications you take: _____

Do you take blood thinner medications ☐ YES ☐ NO

Circle which blood thinner: Eliquis, Plavix, Pradaxa, Coumadin, Xarelto, Aspirin
or list other: _____

Do you take medications for osteoporosis? ☐ YES ☐ NO

Which medication do you take for osteoporosis? Prolia, Fosomax, Boniva, Actonel, Reclast
or list other name: _____

When did you start this medication? What was the date? _____

Do you use smoke? YES: ☐ Cigarettes ☐ Cigar ☐ Cannabis **NO** ☐

Do you use smokeless tobacco (dip)? ☐ YES ☐ NO

<u>Yes</u> <u>No</u> <u>Conditions</u>	<u>Yes</u> <u>No</u> <u>Conditions</u>	<u>Yes</u> <u>No</u> <u>ALLERGIES</u>	
☐ ☐ Abnormal Bleeding	☐ ☐ Heart Attack	☐ ☐ Local anesthetic (i.e Lidocaine)	
☐ ☐ Anemia	☐ ☐ Stroke		☐ ☐ Epinephrine
☐ ☐ Angina Pectoris	☐ ☐ Heart Surgery		☐ ☐ Penicillin/Amoxicillin
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Bypass		☐ ☐ Clindamycin
☐ ☐ Asthma	☐ ☐ Heart Stents		☐ ☐ Corticosteroids (i.e Decadron, Prednisone)
☐ ☐ Blood Transfusion	☐ ☐ Hepatitis		☐ ☐ Sulfa Drugs
☐ ☐ Cancer	☐ ☐ High Blood Pressure		☐ ☐ Pain Medicine (hydrocodone, codeine, etc)
☐ ☐ Chemotherapy	☐ ☐ Joint Replacement		☐ ☐ Aspirin
☐ ☐ Colitis	☐ ☐ Kidney problems		☐ ☐ LATEX RUBBER
☐ ☐ Congenital Heart Defect	☐ ☐ Liver Disease		☐ ☐ Any metals (i.e Nickel, Mercury, etc)
☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ OTHER: please explain _____	
☐ ☐ Difficulty Breathing	☐ ☐ Pacemaker	<u>Yes</u> <u>No</u> <u>IF FEMALE, PLEASE ANSWER</u> ☐ ☐ Are you taking birth control? ☐ ☐ Are you pregnant? If so, how many weeks? _____ ☐ ☐ Are you nursing?	
☐ ☐ Drug Abuse	☐ ☐ Psychiatric Problems		
☐ ☐ Emphysema	☐ ☐ Radiation Therapy		
☐ ☐ Epilepsy	☐ ☐ Rheumatic Fever		
☐ ☐ Facial Surgery	☐ ☐ Seizures		
☐ ☐ Fever Blisters	☐ ☐ Shingles		
☐ ☐ HIV-AIDS	☐ ☐ Sinus Problems		

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of ANY CHANGES TO MY MEDICAL STATUS at future dental appointments.

Signature: _____ Today's Date: _____